

Exhibit A

IN THE UNITED STATES DISTRICT COURT FOR
THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

IN RE: AREDIA® AND ZOMETA®)	No. 3:06-MD-1760
PRODUCTS LIABILITY LITIGATION)	JUDGE CAMPBELL
(MDL No. 1760))	MAGISTRATE JUDGE BROWN
This Document Relates To:)	
ALL CASES)	

PLAINTIFF'S FACT SHEET

Please provide the following information regarding yourself or each individual on whose behalf a personal injury or dental or other monitoring claim is being made. Each question must be answered in full. If you do not know or cannot recall the information needed to answer a question, please indicate that in response to the question. Do not leave any questions unanswered or blank.

In filling out this form, please use the following definitions:

- (1) **“health care provider”** or **“health care practitioner”** means any hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical, dental, oral, psychiatric, mental, emotional or psychological care or advice, and any doctor, physician, surgeon, oncologist, radiologist, dentist, oral and maxillofacial surgeon, pathologist, oral pathologist, natural health provider, homeopath, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, dental, oral, radiological, or mental evaluation or examination or other persons or entities involved in the evaluation, diagnosis, care and/or treatment of you;
- (2) **“document”** means any writing or record of every type that is in your possession or the possession of your counsel, including but not limited to written documents, e-mails, cassettes, videotapes, photographs, charts, computer discs or tapes, x-rays, drawings, graphs, phonorecords, nonidentical copies and other data compilations from which information can be obtained and translated, if necessary, by the respondent through electronic devices into reasonably usable form.

You may attach as many sheets of paper as necessary to fully answer these questions. If you have any documents (as defined above), including, but not limited to, packaging, instructions, or other materials or items that you are requested to produce in response to questions in this fact sheet or that relate to Aredia®, Zometa®, or other bisphosphonate-containing products or medications you allegedly took, or to the incident, injuries, claims or damages that are the subject of your complaint, **you must NOT** dispose of, alter or modify these

documents or materials in any way. You are also required to give all of these documents and materials to your attorney as soon as possible. If you are unclear about these obligations, please contact your attorney.

I. CASE INFORMATION

A. Please state the following for the civil action which you filed:

1. Case Name: _____
2. Civil Action No. in the United States District Court for the Middle District of Tennessee: _____
3. Name of court where the civil action was originally filed and Civil Action No. in that court: _____
4. Please provide the following for the principal attorney representing you.

Attorney Name

Firm

Address

Telephone Number

Fax Number

E-mail Address

B. If you are completing this questionnaire on behalf of someone else (e.g., a deceased person, an incapacitated person), please complete the following:

Your Name

Address

Telephone number

Fax Number

In what capacity are you representing the individual?

If you were appointed by a court, please provide a copy of the order of appointment and state the:

Court _____ Date of Appointment

Your relationship to the deceased or represented person: _____

If you represent a decedent's estate, state the date of the decedent's death:

[If you are completing this questionnaire in a representative capacity, please respond to the remaining questions on behalf of the person who used Aredia® and/or Zometa®. Those questions using the term "You" refer to the person who used these medications or products. If the individual is deceased, please respond as of the time immediately prior to his or her death unless

a different time period is specified.]

II. PERSONAL INFORMATION

A. Last name: _____
First name: _____
Middle name or initial: _____
Maiden name (if any): _____
Other names by which you have been known (from prior marriages or otherwise, if any): _____

B. Gender: Male _____ Female _____

C. Social Security number: _____

D. Driver's license number: _____
State of issuance: _____

E. Date and place of birth: _____

F. Racial/ethnic background: _____

G. Phone number: _____

H. Present home address: _____
1. How long have you lived at this address? _____
2. Who has lived at this address with you and when? _____

I. Identify each prior home address where you have lived during the last twenty (20) years, including time periods of residence and persons, if any, who lived with you at each address and when:

Prior Address	Dates You Lived At Address	Persons, If Any, Who Lived With You At Address And When

J. Current or most recent employer:

Name

Address

Phone number

Dates of employment

Occupation

Description of responsibilities

K. All former employers (including military and self-employment):

Name

Address

Phone number

Dates of employment

Occupation

Description of responsibilities

[Attach additional sheets as necessary with the same information for any additional former employers.]

L. Have you ever served in any branch of the military?

Yes _____ No _____

If yes, answer the following questions:

1. Branch and dates of service: _____

2. Have you been discharged from such service?

Yes _____ No _____

a. If yes, did you receive an honorable discharge?

Yes _____ No _____

b. Were you discharged for any reason relating to your medical, physical, psychiatric or emotional condition?

Yes _____ No _____

If yes, state what that condition was and who diagnosed it. _____

3. Have you ever served overseas?

Yes _____ No _____

If yes, state the location(s) and date(s). _____

M. Have you ever been rejected from military service for any reason relating to your health or physical condition?

Yes _____ No _____

If yes, describe in detail the reason(s) you were rejected from military service. _____

N. Have you ever filed a worker's compensation claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. With whom the claim was filed: _____
4. The claim/docket number, if applicable: _____
5. Nature of the injury or disability claimed: _____

6. Was compensation awarded? _____

a. If yes, what was the payment period or period of disability? _____

b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

[Attach additional sheets as necessary to describe all claims.]

O. Have you ever filed a Social Security disability claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. With whom the claim was filed: _____
4. Nature of the injury or disability claimed: _____

5. Was disability awarded? _____

a. If yes, what was the payment and period of disability? _____

b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

[Attach additional sheets as necessary to describe all claims.]

P. Have you ever filed any other type of disability claim?

Yes _____ No _____

If yes, please state:

1. Date the claim was filed: _____
2. Where the claim was filed: _____
3. Name of the insurer/employer or other party to whom the claim was made: _____
4. Nature of the injury or disability claimed: _____

5. Was disability awarded? _____

a. If yes, what was the payment and period of disability? _____

b. Identify the name, address, telephone number and specialty of the doctors who evaluated you in connection with the claim/disability.

[Attach additional sheets as necessary to describe all claims.]

Q. Have you ever been denied life insurance for reasons relating to your medical, physical, psychiatric or emotional condition?

Yes _____ No _____

If yes, please state when, the name of the company and the company's stated reason(s) for denial. _____

R. Have you ever been denied medical insurance?

Yes _____ No _____

If yes, please state when, the name of the company and the company's stated reason(s) for denial. _____

S. Have you ever brought a lawsuit against anyone aside from the present suit?

Yes _____ No _____

If yes, for each such lawsuit, state (1) the court in which such lawsuit was filed, (2) the case name, (3) the names of the adverse parties, (4) the civil action or docket number assigned to the lawsuit, (5) a description of your claims in the lawsuit, and (6) whether the lawsuit has been resolved and if so, how it was resolved.

T. Have you ever made any other type of legal claim?

Yes _____ No _____

If yes, for each such legal claim, state (1) where the claim was filed (2) to whom the claim was submitted, if it was not filed (3) the caption or name of the claim, if any, (4) the names of the adverse parties, (5) the civil action or docket number assigned to the claim, if any, (6) a description of your claim, and (7) whether the claim has been resolved and if so, how it was resolved. _____

U. Have you been convicted of a felony?

Yes _____ No _____

If yes, please identify the felony for which you were convicted, (1) when you were convicted, (2) where you were convicted, (3) whether you were incarcerated, and if so, for how long you were incarcerated. _____

V. Has any insurance or other company provided medical coverage to you (either directly or through a group or employer) for the period beginning twenty (20) years before your alleged injury through the present?

Yes _____ No _____

If yes, then as to each such company, separately state:

1. Name of the company: _____
2. Address of the company: _____

3. The account/policy number or designation: _____
4. Dates of coverage: _____

W. Have you ever missed work for more than thirty (30) days for reasons related to your health?

Yes _____ No _____

If yes, please state the dates, employer and health condition. _____

III. EDUCATIONAL HISTORY

Identify each school, college, university and other educational institution you have attended, the dates of attendance, courses of study pursued and diplomas or degrees awarded. _____

[Attach additional sheets as necessary.]

IV. FAMILY INFORMATION

A. Have you ever been married?

Yes _____ No _____

B. If yes, for each spouse/former spouse state:

1. Spouse's name: _____

2. Dates of marriage: _____

3. Spouse's date of birth: _____

4. Spouse's occupation: _____

5. Spouse's address and phone number: _____

6. If applicable, why did the marriage end (e.g., divorce, death)? _____

7. If applicable, the date the marriage ended: _____

C. Has anyone filed a loss of consortium claim in connection with your lawsuit regarding Aredia® and/or Zometa®?

Yes _____ No _____

If yes, identify who filed the loss of consortium claim. _____

D. Please provide the following information for your grandparents, parents, siblings and children:

Name	Relationship to You	Date of Birth	Date of Death (if applicable)	Cause of Death (if applicable)	Occupation

V. CANCER BACKGROUND

A. Have you ever been diagnosed with cancer?

Yes _____ No _____

If yes:

1. When were you first diagnosed with cancer? _____

2. What type of cancer was it? _____

3. Who diagnosed you with this cancer? (Please provide the name, address, telephone number and specialty of each diagnosing physician.) _____

4. Please identify the stage and/or grade of your cancer at the following times:

- a. Breast Cancer
 - i. Stage (Stage 0 (non-invasive); **Stage I** (invasive); **Stage II** (invasive); **Stage IIIA** (invasive); **Stage IIIB** (invasive); **Stage IV** (invasive/metastatic))
 - (a) Initial Diagnosis: _____
 - (b) Current Stage: _____
 - ii. Grade (Grade 1 (lowest) through Grade 3 (highest) on the Scarff-Bloom-Richardson grade system)
 - (a) Initial Diagnosis: _____
 - (b) Current Grade: _____
- b. Prostate Cancer
 - i. Stage (Stage I (also known as **Stage A** or **Stage T1**); **Stage II** (also known as **Stage B** or **Stage T2**); **Stage III** (also known as **Stage C** or **Stage T3**); **Stage IV** (also known as **Stage D2** or **Stage M1**))
 - (a) Initial Diagnosis: _____
 - (b) Current Stage: _____
 - ii. Gleason Score (Grades 2-10)
 - (a) Initial Diagnosis: _____
 - (b) Current Score: _____
- c. Multiple Myeloma
 - i. Durie/Salmon Staging System (**Stage I**; **Stage II**; **Stage III**)
 - (a) Initial Diagnosis: _____
 - (b) Current Stage: _____
 - ii. Subclassification (A (relatively normal renal function) or B (abnormal renal function))
 - (a) Initial Diagnosis: _____
 - (b) Current Subclassification: _____
 - iii. International Staging System ("ISS") (**Stage I**; **Stage II** with serum β_2 microglobulin < 3.5 mg/L, **but** serum albumin < 3.5 g/dL; or **Stage II** with serum β_2 microglobulin $3.5 - 5.5$ irrespective of serum albumin; **Stage III**)
 - (a) Initial Diagnosis: _____
 - (b) Current Stage: _____
- d. Other cancer and stage and/or grade
 - i. Type: _____
 - ii. Initial Diagnosis: _____
 - iii. Current Stage and/or Grade: _____

5. Please describe the prognosis you have been given regarding your cancer and identify who provided you with this prognosis. (Please provide the name, address, telephone number and specialty of each physician.) _____

B. Have you been diagnosed with cancer at any time since your first cancer diagnosis (described above)?

Yes _____ No _____

If yes, for EACH subsequent diagnosis please answer the following questions:

1. When were you diagnosed? _____
2. With what type of cancer were you diagnosed? _____
3. Was the cancer a recurrence of a prior cancer?
Yes _____ No _____
4. Who diagnosed the cancer? (Please provide the name, address, telephone number and specialty of each diagnosing physician) _____

[Attach additional pages as necessary]

C. Have you ever been diagnosed with metastatic disease?

Yes _____ No _____

1. When were you diagnosed with metastatic disease? _____
2. Who diagnosed the metastatic disease? (Please provide name, address, telephone number and specialty of each diagnosing physician.) _____
3. For breast cancer patients: What is your estrogen receptor status? _____
4. For breast cancer patients: What is your HER2 neu status? _____
5. For prostate cancer patients: What is your progesterone receptor status? _____

D. Have you ever experienced any of the following:

	Yes	No
Hypercalcemia?		
Spinal cord compression?		
Fractures or breaks of bones?		
Surgery or radiation to the bones in your body?		
Pain, ache or discomfort in your bones?		

E. If you answered "yes" to any of the conditions listed above, for each such condition:

1. State when the condition began and ended. _____

2. Describe any treatment you took to alleviate the condition, including Aredia® and/or Zometa®. _____

3. State the name, address, telephone number and specialty of all physicians and healthcare professionals who treated you for the condition. _____

4. State whether you were advised by anyone that the condition was related to your cancer, and if so, who advised you of this. _____

[Attach additional pages as necessary]

VI. DENTAL BACKGROUND

A. During the twenty (20) year period BEFORE you first used the drug(s) you allege caused your injury in this case:

1. How many times per week did you brush your teeth? _____
2. Was there ever a period of time in your life when you brushed your teeth more or less than the amount indicated above? If so, please indicate when this period of time occurred and how often you brushed your teeth during this period of time. _____

3. Did you ever floss your teeth?
Yes _____ No _____
If yes, answer the following questions:
 - a. How often? _____
 - b. Was there ever a period of time when you flossed your teeth more or less often than that? If so, please indicate when this period of time occurred and how often you flossed your teeth during this period of time. _____

4. How often did you see a dentist for routine check-ups, examinations or teeth cleaning? _____

5. Was there ever a period of time when you saw a dentist more or less frequently than indicated above? If so, please indicate when this period of time occurred and how often you saw a dentist during this period of time.

B. During the period AFTER you first used the drug(s) you allege caused your injury in this case:

1. How many times per week did you brush your teeth? _____
2. Did you ever floss your teeth?
Yes _____ No _____
If yes, answer the following questions:
 - a. How often? _____
3. How often do you see a dentist for routine check-ups, examinations or teeth cleaning? _____

C. Status of teeth BEFORE you first used the drug(s) you allege caused your injury in this case.

1. How many teeth total did you have at the time you first started taking the drug(s) you allege caused your injury in this case? _____
2. Were you missing any teeth (including wisdom teeth or others)?
Yes _____ No _____
If yes, indicate the following:
 - a. How many were you missing? _____
 - b. Which teeth? _____
When did you lose each of those teeth? _____
 - c. How did you lose each of those teeth? _____
3. Were any of the missing teeth extracted?
Yes _____ No _____
If yes, indicate the following:
 - a. How many? _____
 - b. Which teeth? _____
 - c. When did the extraction(s) occur? _____
 - d. Why did you have each of these teeth extracted? _____

e. Who performed each extraction? (please provide the name, address, telephone number and specialty of the person who performed each extraction(s)) _____

4. Before using the drug(s) you allege caused your injury in this case, did you have any loose teeth?
Yes _____ No _____
If yes, how many? _____

5. Did you have any cavities filled BEFORE you first used the drug(s) you allege caused your injury in this case?
Yes _____ No _____
If yes, how many? _____

6. BEFORE you first used the drug(s) you allege caused your injury in this case, did you have any dental implants?
Yes _____ No _____
If yes, indicate the following:
a. What type of dental implant(s) did you have? _____
b. When was each tooth implanted? _____
c. Please provide the name, address, telephone number and specialty of the person who performed each implant. _____

7. BEFORE you first used the drug(s) you allege caused your injury in this case, did you have any dentures, bridges or other artificial fixtures in your mouth?
Yes _____ No _____
If yes, indicate the following:
a. What type of dentures, bridges, or other artificial fixtures did you have? _____
b. When did you start wearing each denture, bridge, or other artificial fixture and was that fixture properly fitted? _____
c. Please provide the name, address, telephone number and specialty of the person who prescribed each denture, bridge or other artificial fixture. _____

8. BEFORE you first used the drug(s) you allege caused your injury in this case, did you have any dental prosthodontics or orthodontia (including, but not limited to, braces)?

Yes _____ No _____

If yes, indicate the following:

a. What type did you have? _____

b. When did you receive it? _____

c. Please provide the name, address, telephone number and specialty of the person who provided you with the prosthodontics or orthodontia. _____

9. BEFORE you first used the drug(s) you allege caused your injury in this case, did you suffer from bruxism or grinding of your teeth?

Yes _____ No _____

If yes, indicate the following:

a. Did you wear a mouth guard at night? _____

b. If so, when did you start wearing the guard and how frequently did you wear it? _____

c. Please provide the name, address, telephone number and specialty of the person who provided you with the mouth guard and/or diagnosed you with bruxism. _____

D. Status of teeth AFTER your use of the drug(s) you allege caused your injury in this case.

1. How many teeth total do you currently have? _____

2. Have you lost any teeth (including wisdom teeth or others) since you began taking the drug(s) you allege caused your injury in this case?

Yes _____ No _____

If yes, indicate the following:

a. How many have you lost? _____

b. Which teeth? _____

c. When did you lose each of those teeth? _____

d. How did you lose each of those teeth? _____

3. Were any of these lost teeth extracted?

Yes _____ No _____

If yes, indicate the following:

a. How many? _____

b. Which teeth? _____

c. When did the extraction(s) occur? _____

d. Why did you have each of these teeth extracted? _____

e. Please provide the name, address, telephone number and specialty of the person who performed each extraction. _____

4. Have you had any loose teeth that were not loose before beginning to take the drug(s) you allege caused your injury in this case?
Yes _____ No _____
If yes, indicate the following:
a. How many? _____

b. Which teeth became loose? _____

c. Did any of these teeth fall out naturally? _____

d. Did you have any of these teeth extracted? _____

5. Did you have any cavities filled AFTER you first used the drug(s) you allege caused your injury in this case?
Yes _____ No _____
If yes, how many? _____
AFTER you first used the drug(s) you allege caused your injury in this case, did you have any dental implants?
Yes _____ No _____
If yes, indicate the following:
a. What type of dental implant(s) did you have? _____

b. When was each implant installed? _____

Please provide the name, address, telephone number and specialty of the person who performed each implant. _____

7. AFTER you first used the drug(s) you allege caused your injury in this case, did you have any dentures, bridges or other artificial fixtures in your mouth?

Yes _____ No _____

If yes, indicate the following:

a. What type of dentures, bridges, or other artificial fixtures did you have? _____

b. When did you start wearing each denture, bridge, or other artificial fixture? _____

c. Please provide the name, address, telephone number and specialty of the person who prescribed each denture, bridge, or other artificial fixture for you. _____

8. AFTER you first used the drug(s) you allege caused your injury in this case, did you have any dental prosthodontics or orthodontia (including, but not limited to, braces)?

Yes _____ No _____

If yes, indicate the following:

a. What type did you have? _____

b. When did you receive the dental prosthodontics or orthodontia? _____

c. Please provide the name, address, telephone number and specialty of the person who provided you with the dental prosthodontics or orthodontia. _____

9. AFTER you first used the drug(s) you allege caused your injury in this case, did you suffer from bruxism or grinding of your teeth?

Yes _____ No _____

If yes, indicate the following:

a. Did you wear a mouth guard at night? _____

b. If so, when you start wearing the guard and how frequently did you wear it? _____

c. Please provide the name, address, telephone number and specialty of the person who provided you with the mouth guard and/or diagnosed you with bruxism. _____

E. At any time BEFORE the injury that you allege you have suffered occurred, had you ever experienced or been diagnosed with any of the following conditions:

	Yes	No
Osteonecrosis of the jaw		
Osteomyelitis		
Infection in the mouth		
Sinus infection		
Bone spurs in the mouth		
Exposed bone in the mouth		
Tooth decay		
Poor healing of infections in the mouth		
Gum disease or infection		
Periodontal disease		
Bleeding gums		
Grinding of the teeth		
Temporomandibular joint [TMJ] problems		
Dental pain		
Abscesses		
Lesions in the mouth		
Cancer of the mouth		
Herpes [in or around the mouth]		
Lockjaw		
Mandibular exostosis (bony outgrowth)		
Pain (persistent or otherwise) in the mouth or jaw		
Swelling in the mouth or jaw		
Non-healing sore in the mouth or jaw		
Draining fistula		
Numbness of the lip, chin, mouth or jaw		
“Heaviness” of the jaw		
Burning or tingling in the jaw		
Limited range of motion in the jaw		
Edentulous (toothless) regions in the mouth		

F. If you responded “yes” to any of the above, please provide the following information for each condition identified above:

1. Condition: _____

Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

2. Condition: _____
Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

3. Condition: _____
Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

[Attach additional sheets as necessary until all listed conditions have been described.]

G. State whether you were ever given any of the following dental or oral procedures/tests at any time BEFORE the injury that you allege you suffered occurred.

	Yes	No
Gingivectomy or gum resection		
Periodontal surgery		
Oral surgery		
Root canal (endodontic procedures)		
Root planing, scaling, or other treatment for gum disease		
Any invasive dental procedure		
Dental procedure to fill or repair cavities		
Orthodontic work		
Bone trimming		

H. For each procedure/test for which you answered "yes," please identify the following information:

Test/Procedure _____ Physician/Dentist _____ Approximate date _____

Test/Procedure	Physician/Dentist	Approximate date
Test/Procedure	Physician/Dentist	Approximate date

[Attach additional sheets as necessary.]

VII. OTHER MEDICAL BACKGROUND AND INFORMATION

A. To the best of your knowledge, did you use or take any of the following medications or substances BEFORE the injury that you allege you suffered occurred? If yes, please provide the first and last date on which you took the medication or substance.

	Yes	No	Date First Taken	Date Last Taken
1. Corticosteroids				
a. Dexamethasone (Decadron)				
b. Prednisone, methyl prednisone				
c. Glucocorticosteroids				
d. Other corticosteroids				
2. Dental Anesthesia [including, but not limited to, Novocaine]				
3. Radiation Therapy				
4. Chemotherapy				
a. 5-Fluorouracil (5-Fu, Adrucil) (IV)				
b. Capecitabine (Xeloda) (oral)				
c. Anthracyclines				
i. Doxorubicin (Adriamycin)				
ii. Epirubicin (Ellence)				
iii. EC (Doxorubicin Epirubicin/ cyclophosphamide)				
iv. Mitoxantrone (Novantrone)				
d. Bortezomib (Velcade)				
e. Busulfan (Myleran, Busulfex)				
f. Cyclophosphamide (Cytoxan)				
g. "CMF therapy" (chemotherapy using the drugs Cyclophosphamide, Methotrexate (Amethopterin, Mexate, Folex, Rheumatrex, Trexall) and 5-Fluorouracil)				
h. Dolasetron (Anzemet) (anti-nausea)				
i. Estramustine (Emcyt, Estracyte)				
j. Flutamide (Eulexin, Euflex)				
k. Gemcitabine (Gemzar)				
l. Interferon				

		Yes	No	Date First Taken	Date Last Taken
m.	Melphalan (Alkeran, L-PAM)				
n.	Thalidomide (Thalomid)				
o.	Vincristine (Oncovin, Vincasar PFS)				
p.	VAD (Vincristine, Adriamycin, Dexamethasone, cyclophosphamide)				
q.	Vinorelbine (Navelbine)				
5.	Hormonal Therapy (including, but not limited to, anti-estrogens, aromatase inhibitors, and anti-androgens/androgen deprivation therapy)				
a.	Anastrozole (Arimidex)				
b.	Bicalutamide (Casodex)				
c.	Estradiol (Estrace, Climara, Estraderm)				
d.	Exemestane (Aromasin)				
e.	Flutamide (Eulexin, Euflex)				
f.	Fulvestrant (Faslodex)				
g.	Goserelin acetate (Zoladex)				
h.	Letrozole (Femara)				
i.	Leuprolide (Lupron, Eligard)				
j.	Megestrol (Megace)				
k.	Nilutamide (Nilandron)				
l.	Taxanes				
i.	Docetaxel (Taxotere)				
ii.	Paclitaxel (Taxol, Abraxane)				
m.	Tamoxifen (Nolvadex)				
n.	Toremifene (Fareston)				
o.	Trastuzumab (Herceptin)				
6.	Blood Pressure (hypertension) Medication				
a.	Amlodipine (Norvasc)				
b.	Bendrofluazide (Aprinox)				
c.	Diltiazem (Cardizem, Dilacor, Tiazac)				
d.	Perindopril (Aceon)				
e.	Verapamil (Calan, Verelan, Verelan PM, Isoptin, Covera-HS)				
f.	Other (describe: _____)				
7.	Cholesterol-lowering Medication				
a.	Atorvastatin (Lipitor)				
b.	Simvastatin (Zocor)				

	Yes	No	Date First Taken	Date Last Taken
c. Other (describe:)				
8. Celecoxib (Celebrex)				
9. Diphenhydramine (Benadryl)				
10. Dutasteride (Avodart)				
11. Esomeprazole (Nexium)				
12. Ferrous Sulfate				
13. Hydroxychloroquine (Plaquenil)				
14. Isotretinoin (Accutane)				
15. Itraconazole (Sporanox)				
16. Leflunomide (Arava)				
17. Metformin (Glucophage)				
18. Morphine				
19. Omeprazole (Prilosec, Losec, Rapinex)				
20. Ranitidine (Zantac)				
21. Rosiglitazone (Avandia)				
22. Sertraline (Zoloft, Sertraline, Lustral, other)				
23. Sulfamethoxazole (Gantanol)				
24. Tramadol (Ultram)				
25. Trimethoprim (Bactrim)				
26. Warfarin (Coumadin, Marevan)				
27. Antidepressants				
28. Psychiatric Medications				
29. Cocaine/Crack Cocaine				
30. Heroin or Methadone				
31. Marijuana or Hashish				
32. LSD, Ecstasy, ICE, PCP				
33. Amphetamines				
34. Inhaled Nonprescription Substances (e.g., inhalation of glue or toluene)				
35. Dietary Supplements, Vitamins				
36. Herbal Products (describe:)				

B. Have you regularly taken any other prescription medicines in the last 10 years?
 Yes _____ No _____

If yes, please list the medications, the first and last dates of ingestion, and reasons for taking each. _____

C. Have you participated in any clinical trials or taken any experimental drugs?

Yes _____ No _____

If yes, please indicate when you participated in such trials, where the trials took place, which drugs you took, and for what condition you took such drugs. _____

D. Smoking History

1. Have you ever smoked cigarettes?

Yes _____ No _____ **If no, skip to D.4.**

2. Do you currently smoke cigarettes?

Yes _____ No _____

a. If yes, state amount smoked: _____ packs per day for _____ years of the following brands of cigarettes: _____

b. If no, state date on which smoking ceased _____ and state amount smoked: _____ packs per day for _____ years of the following brands of cigarettes: _____

3. At the time that you sustained the injuries alleged in the Complaint, did you smoke cigarettes?

Yes _____ No _____

If yes, state amount smoked: _____ packs per day for _____ years prior to date of the injury.

4. Have you ever smoked cigars or pipe tobacco?

Yes _____ No _____ **If no, skip to D.7.**

5. Do you currently smoke cigars or pipe tobacco?

Yes _____ No _____

a. If yes, state amount smoked: _____ cigars/pipes per day for _____ years.

b. If no, state date on which smoking ceased _____ and state amount smoked: _____ cigars/pipes per day for _____ years.

6. At the time that you sustained the injuries alleged in the Complaint, were you a smoker of cigars or pipe tobacco?

Yes _____ No _____

If yes, state amount smoked: _____ cigars/pipes per day for _____ years prior to date of the injury.

7. Have you ever dipped snuff/chewed tobacco?

Yes _____ No _____

a. If yes, state amount dipped/chewed: _____ cans/plugs per day for _____ years.

b. If no, state date on which dipping/chewing ceased _____ and state amount dipped/chewed: _____ cans/plugs per day for _____ years.

E. Drinking History

1. Do you currently drink alcohol (beer, wine, whiskey, etc.)?

Yes _____ No _____

If yes, check which represents your current alcohol consumption

_____ 1-5 drinks per week

_____ 6-10 drinks per week

_____ 11-14 drinks per week

_____ 15 or more drinks per week

_____ Other (Describe: _____)

2. Have you ever drunk alcohol (beer, wine, whiskey, etc.)?

Yes _____ No _____

If yes, please check which represents your greatest alcohol consumption over an extended (six (6) months or greater) period within the last 20 years?

_____ 1-5 drinks per week

_____ 6-10 drinks per week

_____ 11-14 drinks per week

_____ 15 or more drinks per week

_____ Other (Describe: _____)

When was this period? _____

3. Check which represents your weekly alcohol consumption during the period you commenced taking you first used the used the drug(s) you allege caused your injury in this case through the onset of your alleged injury.

_____ 0 drinks per week

_____ 1-5 drinks per week

_____ 6 -10 drinks per week

_____ 11 -14 drinks per week

_____ 15 or more drinks per week

_____ Other (D escribe: _____)

F. Have you ever experienced or been diagnosed or treated for any of the following:

	Yes	No
1. Necrosis, avascular necrosis, or osteonecrosis in any part of the body		

	Yes	No
2. Osteomyelitis		
3. Diseases of the jaw or oral cavity		
4. Osteoporosis		
5. Paget's disease		
6. Pancytopenia secondary to cancer and/or cancer treatment		
7. Sickle cell disease		
8. Gaucher's disease		
9. Leiden mutation of the factor V gene		
10. Coagulation or clotting abnormalities or disorders, such as blood clots or thrombosis		
11. Abnormality of blood vessels or circulatory system		
12. Hyperlipidemia and lipid disorders, such as but not limited to high cholesterol		
13. Autoimmune or connective tissue disorders		
a. Systemic lupus erythematosus		
b. Rheumatoid arthritis		
c. Vasculitis		
d. Other (describe: _____)		
14. Other rheumatological condition (describe: _____)		
15. Acquired Immunodeficiency Disease Syndrome (AIDS) or HIV		
16. Vascular insufficiency		
17. Renal transplant/disease		
a. Renal impairment		
b. Renal disease		
18. Caisson's disease/barotrauma		
19. Pancreatitis		
20. High blood pressure or hypertension		
21. Arterial disease		
22. Peripheral vascular disease		
23. Infection		
24. Diabetes Mellitus		
25. Fungal infections (including, but not limited to, Aspergillus fungus)		
26. Fibrous Dysplasia		
27. Secondary hyperparathyroidism/ hypocalcemia		
28. Local ischemia		

	Yes	No
29. Hypoproteinemia		
30. Hyperviscosity syndrome		
31. Anemia or leucopenia		
32. Thrombocytopenia		
33. Thrombophilia or hypofibrinolysis		
34. Asthma		
35. Blood disorders or dyscrasias		
36. Persistence of low serum calcium levels (hypocalcemia)		
37. Persistence of high serum parathyroid levels (hyperparathyroidism)		

G. If you responded "yes" to any of the above, please identify the condition, the date of onset, state the name of the physician or other person who made the diagnosis or informed you of the condition, and identify any medication prescribed for the condition.

1. Condition: _____

Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

2. Condition: _____

Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

3. Condition: _____

Date of onset: _____

Please provide the name, address, telephone number and specialty of the person who diagnosed the condition. _____

Generic name, brand name, strength and daily dose of any medication prescribed (or taken without prescription): _____

[Attach additional sheets as necessary until all listed conditions have been described.]

H. State whether you experienced or were treated for any psychological, psychiatric or emotional problem (including depression) BEFORE you first used Aredia® and/or Zometa®:

Yes _____ No _____

If yes, please provide the following information for each condition:

1. Describe the symptoms experienced. _____
2. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____
3. Please provide the name and address of facility or hospital, if any, where the treatment was provided. _____
4. Condition treated: _____
5. When treated: _____

[Attach additional sheets as necessary.]

I. Has any physician, health practitioner or any other person ever told you that you have a genetic predisposition for developing osteonecrosis of the jaw or osteonecrosis of any other part of the body?

If yes, answer the following:

1. Please provide the name, address, telephone number and specialty of the person who told you this. _____
2. What were you specifically told about your genetic predisposition? _____
3. When were you told this information? _____

J. Have you ever suffered any traumatic injury to your head, neck, mouth or jaw?

Yes _____ No _____

If yes, please state:

1. When the injury occurred. _____
2. The nature of the injury, including what part of the body was injured. _____

3. Please provide the name, address, telephone number and specialty of the person who provided the diagnosis and/or treatment. _____

4. Please provide the name and address of facility or hospital, if any, where the treatment was provided. _____

5. Please identify the medications taken to treat the injury. _____

K. To the best of your knowledge, state whether you underwent any of the following tests, procedures, or surgeries BEFORE the injury you allege you suffered occurred.

	Yes	No
1. Skeletal bone scan (scintigraphy), Dual Energy X-Ray Absorptiometry (DEXA) scan, or nuclear medicine imaging		
2. Dental x-rays, panorexes, or other dental imaging		
3. Echocardiogram		
4. Electrocardiogram		
5. Electroencephalogram		
6. Magnetoencephalography		
7. Arteriogram or angiogram		
8. MRI (including functional MRI, or MRI spectroscopy), CT or CTA scans or x-ray		
9. MRA (magnetic resonance angiography)		
10. Doppler scans		
11. Ultrasound		
12. PET scans		
13. Biopsies		
14. Interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures		
15. Other diagnostic test or imaging of the mouth or jaw		
16. Stem cell or organ transplant		
17. Prehematopoietic stem cell transplantation		
18. Vascular surgery		
19. Any other surgery (describe: _____)		

L. For each test, procedure, or surgery for which you answered "yes," please identify the treating physician and approximate date of the test.

Test/Procedure/Surgery	Treating Physician	Approximate date
Test/Procedure/Surgery	Treating Physician	Approximate date
Test/Procedure/Surgery [Attach additional sheets as necessary.]	Treating Physician	Approximate date

VIII. AREDIA®, ZOMETA®, AND OTHER BISPHOSPHONATE USE

A. Identify which of the following medications you have taken:

	Yes	No
1. Aredia®:		
2. Zometa®:		
3. Fosamax®:		
4. Actonel®:		
5. Boniva®:		
6. Didronel®:		
7. Skelid®:		
8. Ostac®:		
9. Bonefos®:		

B. Complete the following information for each drug identified above:

Dates of Use of Drug	Dosage	Physician Who Prescribed	Address of Prescribing Physician	Condition(s) Treated	Name and Street Address of Location Where Drug Was Infused, Injected or Taken

C. Were you given any written instructions or warnings, including any packaging, package inserts, pamphlets, or brochures BEFORE receiving the drug(s) at issue?

Yes _____ No _____ I don't recall _____

1. If yes, please provide the name, address, telephone number and specialty of the person who gave you the instructions or warnings. _____

2. If yes, identify what the warnings or instructions said. _____

3. Do you still have this information? If yes, attach it to your responses. If no, what happened to it? _____

D. Were you given any oral instructions or warnings regarding your use of the drug(s) BEFORE receiving the drug(s) at issue?

Yes _____ No _____ I don't recall _____
1. If yes, please provide the name, address, telephone number and specialty of the person who gave you the instructions or warnings. _____

2. Were they in writing? _____
3. What were you told about the warnings or instructions? _____

E. Has any healthcare provider, or anyone else, ever explained to you the reasons why you were prescribed Aredia® and/or Zometa®?

Yes _____ No _____ I don't recall _____
1. If yes, please provide the name, address, telephone number and specialty of each person who explained this to you. _____

2. When was this explained to you? _____
3. What was the explanation given to you? _____

F. Were you advised of the benefits of taking Aredia® and/or Zometa®?

Yes _____ No _____ I don't recall _____
1. If yes, please provide the name, address, telephone number and specialty of each person who advised you of the benefits of taking Aredia® and/or Zometa®? _____

2. What were you advised regarding the benefits of taking Aredia® and/or Zometa®? _____

3. If you received any written information about the benefits of Aredia® and/or Zometa®, do you still have this information? If yes, attach it to your responses. If no, what happened to it? _____

G. Have you ever seen or received any advertising, marketing, or any other materials regarding the promotion of Aredia® and/or Zometa®?

Yes _____ No _____ I don't recall _____

1. If yes, where did you see this material? _____

2. Describe the materials you saw. _____

3. Please provide the name, address, telephone number and specialty of each person who provided it to you. _____

4. Do you still have this information?

Yes _____ No _____

a. If yes, attach it to your responses. _____

b. If no, what happened to it? Identify what the material said or pictured. _____

H. Have you ever had any communications with Novartis Pharmaceuticals Corporation ("NPC")?

Yes _____ No _____

If yes, then answer the following:

1. With whom did you communicate? _____

2. By what method did this communication occur (for example, telephone, letter, e-mail, etc.)? If the method of communication was written, please attach a copy of each communication to your response. _____

3. When did the communication occur? _____

4. Who initiated the communication? If someone other than you, who? (please provide his or her name, address and telephone number) _____

5. Describe the contents of the communication (for example, what each participant said; what, if any, agreements or conclusions were reached, etc.). _____

6. Has anyone else, including any of your physicians, family members, or others, ever contacted NPC on your behalf or about your medical condition? If so, provide each person's name, address and telephone number. _____

I. Have you ever had any communications with anyone other than NPC regarding Aredia® and/or Zometa®?

Yes _____ No _____

If yes, then answer the following:

1. With whom did you communicate? _____

2. By what method did this communication occur (for example, telephone, letter, e-mail, etc.)? If the method of communication was written, please attach a copy of each communication to your response. _____

3. When did the communication occur?

4. Who initiated the communication or did someone else? If someone other than you, who? (please provide his or her name, address and telephone number) _____

5. Describe the contents of the communication (for example, what each participant said; what, if any, agreements or conclusions were reached, etc.) _____

J. Have you ever visited any website (including any chat rooms) regarding Aredia®, Zometa®, or other bisphosphonates?
Yes _____ No _____
If yes, identify all websites or chat rooms visited and approximate dates of visit.

K. For what disease or condition were you prescribed each of the medications identified in section VIII.A:

1. Injury, illness, or disability: _____
2. Date(s) of onset: _____
3. Date(s) of diagnosis: _____
4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

5. List the treatment (surgery, medications taken or prescribed) for the injury, illness or disability. _____

L. At the time you first began taking Aredia®, Zometa®, or other bisphosphonates did you suffer from any other physical injuries, illnesses or disabilities other than the disease or condition identified in B. above?

Yes _____ No _____
If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis

1. Injury, illness, or disability: _____

2. Symptom(s): _____

3. Date(s) of onset: _____

4. Date(s) of diagnosis: _____

5. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed. _____

IX. THE INJURY

A. If you are making a claim for present or past physical injuries or illness from taking Aredia®, Zometa®, or other bisphosphonates, please list each injury separately and provide the information below:

1. Injury: _____

a. Full description of injury: _____

b. Do you still have that injury or illness?
Yes _____ No _____

c. On what date and time did you first experience any symptoms you believe are related to the injuries or illnesses alleged above? _____

d. What symptoms did you experience at first? _____

e. In what city and state were you when you experienced those symptoms?
City: _____ State: _____

f. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, telephone numbers and relationship to you. _____

g. When did you first contact a doctor or healthcare professional concerning this injury? _____

h. Who did you contact first? (provide the name, address, telephone number and specialty of the person) _____

i. If you were taken to a doctor or health care facility for the injury alleged in the Complaint, state the name and address of the persons, police department, fire department, emergency medical workers, or ambulance company who took you to the doctor or health care facility? _____

j. When were you formally diagnosed with this injury? _____

k. Who diagnosed you with this injury? (provide the name, address, telephone number and specialty of the person) _____

l. What treatment did you receive for this injury? _____

m. What product(s) do you claim caused this injury? _____

[Attach additional sheets as necessary for each present or past physical injury or illness you allege was caused by Aredia®, Zometa®, or other bisphosphonates.]

B. Have you had discussions with any physician(s), dentist(s), or other health care practitioner(s) about whether your condition is related to the use of Aredia® and/or Zometa®?

Yes _____ No _____

If yes, please identify:

Name of doctor: _____

Address: _____

Specialty: _____

Date of Discussion(s): _____

and circle all of the following that describe your discussion:

1. I was told my condition is related to drug(s) other than Aredia® and/or Zometa®; the drug(s): _____
2. I was told my condition is related to the following medical condition or disease: _____
3. I was told my condition is related to the use of Aredia® and/or Zometa®.
4. I was told my condition is not related to the use of Aredia® and/or Zometa®.
5. I was told my condition may be related to the use Aredia® and/or Zometa®.

6. I was told by the doctor that he does not know whether my condition is related to the use of Aredia® and/or Zometa®.

7. I don't recall what I was told.

[If discussed with more than one doctor, please copy and complete Part B for each.]

C. Do you currently suffer from any physical injuries, illnesses or disabilities other than those you believe were caused by Aredia®, Zometa®, or other bisphosphonates?

Yes No

If yes, identify the injury, illness, or disability, symptoms, date(s) of onset and dates(s) of diagnosis:

1. Injury, illness, or disability: _____

1. Symptom(s): _____

Date(s) of onset:

4. Please provide the name, address, telephone number and specialty of the person by whom the injury, illness or disability was first diagnosed

5. What caused that injury?

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D. If you are making a claim for present or past psychological, cognitive or emotional injury as a consequence of using Aredia® and/or Zometa®, or other bisphosphonates, please list each injury separately and provide the information below:

1. Injury: _____

a. Full description of injury: _____

b. Do you still have that injury or illness?

Yes _____ No _____

c. On what date and time did you first experience any symptoms you believe are related to the injuries or illnesses alleged above?

d. What symptoms did you experience at first? _____

e. In what city and state were you when you experienced those symptoms?
City: _____ State: _____

f. Were there any witnesses to the symptoms identified above? If so, state their names, addresses, telephone numbers and relationship to you. _____

g. When did you first contact a doctor or healthcare professional concerning this injury? _____

h. Who did you contact first? (provide the name, address, telephone number and specialty of the person) _____

i. When were you formally diagnosed with this injury? _____

j. Who diagnosed you with this injury? (provide the name, address, telephone number and specialty of the person) _____

k. What treatment did you receive for this injury? _____

l. What product(s) do you claim caused this injury? _____

[Attach additional sheets as necessary for each present or past psychological, cognitive or emotional injury you allege was caused by Aredia®, Zometa®, or other bisphosphonates.]

E. Do you claim that your treatment with Aredia® and/or Zometa® increased your risk of a future injury or harm that you have not yet experienced?

Yes _____ No _____

If yes, identify and describe each and every such future injury or harm and for each, identify the basis for your contention. _____

F. Have you had any discussions with any physician(s), dentist(s), or other health care practitioner(s) about whether your treatment with Aredia® and/or Zometa® put you at increased risk of injury or harm?

Yes _____ No _____

If yes, please identify:

Name of doctor: _____

Address: _____

Specialty: _____

Date of Discussion(s): _____

Identify what the physician told you: _____

G. Do you claim that your treatment with bisphosphonates, other than Aredia® and/or Zometa®, increased your risk of a future injury or harm that you have not yet experienced?

Yes _____ No _____

1. If yes, identify and describe each and every such future injury or harm and for each, identify the basis for your contention. _____

2. Have you had any discussions with any physician(s), dentist(s), or other health care practitioner(s) about whether your treatment with bisphosphonates, other than Aredia® and/or Zometa®, put you at increased risk of injury or harm?

Yes _____ No _____

If yes, please identify:

Name of doctor: _____

Address: _____

Specialty: _____

Date of Discussion(s): _____

Identify what the physician told you: _____

X. DAMAGE CLAIMS

A. Complete the following information with respect to your employment for ten (10) years prior to your alleged use of Aredia® and/or Zometa® to the present.

Employer	Address	Type of Business/ Position	Dates of Employment	Salary	Overtime	Bonus

State the total amount of time which you have lost from work as a result of any condition which you claim or believe was caused by your use of Aredia® and/or Zometa® and the amount of income which you lost.

Total time _____ days

Total income lost \$ _____

B. Have you paid or incurred any medical expenses, including amounts billed or paid by insurers and other third party payors, which are related to any condition which you claim or believe was caused by your use of Aredia® and/or Zometa® for which you seek recovery in the action which you have filed?

Yes _____ No _____

If yes, please state the total amount of such expenses at this time. \$ _____

C. If you are making any claims for other out-of-pocket expenses, please complete the following:

1. For what expenses? _____

2. Amount of fees or expenses: _____

D. Please identify all persons who you believe possess information concerning your injury, your current medical condition, the underlying cancer or illness for which you took Aredia® and/or Zometa®, and/or your claims in this case and for each, state their name, address, telephone number and a description of the information you believe they possess. _____

XI. DOCUMENTS

Please attach the following documents to this declaration, to the extent that such documents are currently in your possession or in the possession of your lawyers.

- A. For each health care practitioner who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental, or mental condition at any time, produce an executed copy of the release form attached to this Plaintiff's Fact Sheet as Ex. A, authorizing NPC to obtain medical records from each health care practitioner.
- B. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from each health care practitioner who later becomes known to NPC who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental, or mental condition at any time.
- C. For each hospital, clinic or any other facility at which you have been treated for any medical, dental, or mental condition at any time, produce an executed copy of the release form attached as Ex. A, authorizing NPC to obtain medical records from each such hospital, clinic or any other facility.
- D. Produce an additional TEN ORIGINAL SIGNED copies of the release form attached as Ex. A, leaving blank the name to whom the release is directed, authorizing NPC to obtain medical records from any hospital, clinic or any other facility that later becomes known to NPC and at which you have been treated for any medical, dental or mental condition at any time.
- E. For each health care practitioner, who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at any time, at or in affiliation with a Veteran's Administration facility, produce an executed copy of the release form attached as Ex. B, authorizing NPC to obtain medical records from each health care practitioner.
- F. For each health care practitioner, who has examined you, treated you, or consulted with other health care practitioners regarding your medical, dental or mental condition at any time, produce an executed copy of the release form attached as Ex. C, authorizing that person to review your medical records, participate in informal *ex parte* communications with NPC's attorneys, and give testimony regarding your medical condition.
- G. For each psychologist, psychiatrist or other mental health care practitioner who has examined or treated you for any psychological, psychiatric, or emotional injuries, illnesses and/or conditions allegedly suffered as a result of your treatment with Aredia® and/or Zometa®, produce an executed copy of the release form attached as Ex. D, authorizing NPC to obtain your psychotherapy notes generated by any such mental health care practitioner.
- H. A copy of all medical records from any health care provider (e.g., doctor, physician, surgeon, hospital or other facility where medical care or treatment is

rendered, oncologist, radiologist, dentist, oral and maxillofacial surgeon, health care provider, pathologist, oral pathologist, natural health provider, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, radiological, or mental evaluation or examination) who treated you for any disease, condition or symptom referred to in any or your responses to the questions above.

- I. A copy of all medical records from any health care provider (e.g., doctor, physician, surgeon, hospital or other facility where medical care or treatment is rendered, oncologist, radiologist, dentist, oral and maxillofacial surgeon, health care provider, pathologist, oral pathologist, natural health provider, osteopath, chiropractor, paramedic, nurse (registered or otherwise), physiotherapist, psychologist, psychiatrist, therapist, or any other person practicing any healing art, or performing any physical, radiological, or mental evaluation or examination) who treated you at any time for any cancer, periodontal disease, dental problem or routine check-ups, or osteonecrosis of the jaw.
- J. To the extent not included in the foregoing, all records relating to any examination by a physician, dentist, or other health care provider as defined above, conducted for any purpose, in the period prior to the date upon which you used Aredia® and/or Zometa®.
- K. All radiological or other images or recordings of you including but not limited to x-rays; skeletal bone scans, scintigraphy, or nuclear medicine images; dental films, panorexes, or images; CT or CTA scans; MRI, MRA, functional MRI, or MRI spectroscopy; electroencephalograms (EEG), electrocardiograms and echocardiograms (EKG/ECG); magnetoencephalography; angiograms; arteriograms; ultrasound; doppler scans; PET scans; biopsies; and interventional radiology procedure images, such as organ procedures or vascular interventional radiology procedures.
- L. If you have been the claimant or subject of any worker's compensation, Social Security or other disability proceeding, all documents relating to such proceeding.
- M. Produce executed copies of each of the authorizations, attached as Ex. E, authorizing NPC to obtain all documents discussing, describing or memorializing your requests for Social Security, disability insurance, or workers' compensation benefits.
- N. If you claim you have suffered a loss of earnings or earning capacity, your federal tax returns for each of the years from ten (10) years prior to your injury to the present.
- O. Produce executed copies of each of the authorizations, attached as Ex. F, authorizing NPC to obtain your Federal and State income tax returns for each of the years from ten (10) years prior to your injury to the present.
- P. Produce executed copies of each of the authorizations, attached as Ex. G, authorizing NPC to obtain your earnings information from the Social Security Administration.

Q. All documents relating to your employment at any time, including documents relating to attendance, leave of absences (whether for vacation, sick leave or other reasons), reported injuries, promotions and demotions, performance evaluations, reports of health examinations, job applications, and wages paid and/or earnings given (including W-2 forms), and all other pertinent documents, including any and all medical, psychological, or testing records or memoranda.

R. For each of your prior employers, produce two executed copies of the release form attached as Ex. H, permitting NPC to obtain your employment records, including W-2 forms.

S. For your current employer, produce two executed copies of the release form attached as Ex. H, permitting NPC to obtain your employment records, including W-2 forms.

T. If you have served in the military, produce an executed copy of the release form attached as Ex. I, permitting NPC to obtain your military personnel, service, and health records.

U. Copies of all documents from any healthcare provider (as defined above) or others discussing, describing, relating to, or memorializing your treatment with Aredia® and/or Zometa® or to any condition you claim is related to the use of Aredia® and/or Zometa®.

V. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, handouts or other materials distributed with or provided to you in connection with your use of Aredia® and/or Zometa®.

W. Copies of advertisements, videos, written materials or promotions for Aredia® and/or Zometa® which you saw prior to use of the drug(s).

X. All documents relating to Aredia® and/or Zometa® or any alleged health risks or hazards related to these drugs in your possession at or before the time of the injury alleged in your Complaint.

Y. All documents you (and not your lawyer) obtained directly or indirectly from NPC.

Z. All photographs, drawings, journals, slides or videos relating to your alleged injury after using Aredia® and/or Zometa®, including any “day-in-the-life” videotapes.

AA. Any diary, calendar or any other writing or recording made by you, or by any other person, describing, discussing, explaining or referring to the injuries, damages, or causes of action alleged by you in the Complaint.

BB. Any diary, calendar or any other writing or recording made by you, or by any other person, describing, discussing, explaining or referring to the underlying illness or disease for which you received Aredia® and/or Zometa®.

CC. Copies of all documents you (and not your attorneys) obtained from any source related to Aredia® and/or Zometa® or to the alleged effects of such medications.

DD. If you claim any loss from medical expenses, copies of all bills from any

physician, hospital, pharmacy or other health care provider.

EE. Decedent's death certificate (if applicable).

DECLARATION

I declare under penalty of perjury that all of the information provided in this Plaintiff's Fact Sheet is true and correct to the best of my knowledge, information and belief, that I have completed the List of Medical Providers and Other Sources of Information appended hereto, which is true and correct to the best of my knowledge, information and belief, that I have supplied all the documents requested in Part XII of this declaration, to the extent that such documents are in my possession or in the possession of my lawyers, and that I have supplied the authorizations attached to this declaration.

Signature

Date

IN RE: AREDIA AND ZOMETA PRODUCTS LIABILITY LITIGATION
UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF TENNESSEE
MDL NO. 1760

LIST OF MEDICAL AND OTHER HEALTH CARE PROVIDERS
AND OTHER SOURCES OF INFORMATION

EACH PLAINTIFF WHO IS REQUIRED TO COMPLETE A DECLARATION MUST FULLY AND ACCURATELY COMPLETE THIS FORM LISTING MEDICAL AND OTHER HEALTH CARE PROVIDERS AND OTHER SOURCES OF INFORMATION AS REQUESTED.

A. Identify your current primary care physician(s):

Name

Street Address

City, State, Zip Code

B. Identify each of your primary care physicians for the 20 years prior to your use of Aredia® and/or Zometa® through the present.

3.

Name

Last known address

Approximate dates physician was primary care physician for you

4.

Name

Last known address

Approximate dates physician was primary care physician for you

5.

Name

Last known address

Approximate dates physician was primary care physician for you

[Attach additional sheets if necessary.]

C. Identify each dentist, oral and maxillofacial surgeon, orthodontist, periodontist, or other health care provider involved in providing dental care or treatment who has

ever seen or treated you.

1.

Name

Last known address

Specialty

Approximate dates of treatment

2.

Name

Last known address

Specialty

Approximate dates of treatment

3.

Name

Last known address

Specialty

Approximate dates of treatment

[Attach additional sheets if necessary.]

D. Identify each oncologist or other health care provider involved in the treatment and medical care for cancer, or the underlying illness for which you took Aredia® and/or Zometa®, whom has ever seen or treated you.

1.

Name

Last known address

Specialty

Approximate dates of treatment

2.

Name

Last known address

Specialty

Approximate dates of treatment

3.

Name

Last known address

Specialty

Approximate dates of treatment

[Attach additional sheets if necessary.]

F. Identify each hospital or healthcare facility where you have received treatment (including, but not limited to outpatient treatment or treatment in an emergency room) during the 20 years prior to your treatment with Aredia® and/or Zometa® through the present.

1.

Name

Address

Approximate dates of treatment

2.

Name

Address

Approximate dates of treatment

3.

Name

Address

Approximate dates of treatment

[Attach additional sheets if necessary.]

G. Identify each other physician, dentist or healthcare practitioner whom you have seen or are currently seeing for examination evaluation, diagnosis or treatment of any condition, injury, physical infirmity, disability, sickness, ailment, or affliction.

1.

Name

Address

Specialty

Approximate dates of treatment

2. _____
Name _____

Address _____

Specialty _____

Approximate dates of treatment _____

3. _____
Name _____

Address _____

Specialty _____

Approximate dates of treatment _____

[Attach additional sheets if necessary.]

H. Identify each pharmacy, drugstore or place where you have had prescriptions filled during the 20 years prior to your use of Aredia® and/or Zometa® through the present.

1. _____
Name _____

Address _____

Approximate dates _____

2. _____
Name _____

Address _____

Approximate dates _____

3. _____
Name _____

Address _____

Approximate dates _____

[Attach additional sheets if necessary.]

I. Identify each psychiatrist, psychologist, mental health counselor, therapist and/or social worker from whom you have received treatment or with whom you have consulted regarding your health during the 20 years prior to your use of Aredia® and/or Zometa®, or other bisphosphonates through the present:

1. _____
Name _____
Address _____
Specialty _____
Approximate dates of treatment _____

2. _____
Name _____
Address _____
Specialty _____
Approximate dates of treatment _____

3. _____
Name _____
Address _____
Specialty _____
Approximate dates of treatment _____

[Attach additional sheets if necessary.]

J. If you have submitted a claim for social security disability benefits in the 20 years prior to your use of Aredia® and/or Zometa® through the present, state the name and address of the office most likely to have records concerning your claim.

Name _____
Address _____
Approximate date(s) of claim(s) submitted _____
[Attach additional sheets if necessary.]

K. If you have submitted a claim for workers compensation in the 20 years prior to your use of Aredia® and/or Zometa® through the present, state the name and address of the office which is most likely to have records concerning your claim.

Name _____
Address _____
Approximate date(s) of claim(s) submitted _____
[Attach additional sheets if necessary.]